Texas Department of Insurance
Division of Workers' Compensation
Medical Fee Dispute Resolution, MS-48
7551 Metro Center Drive, Suite 100 • Austin, Texas 78744-1645
518-804-4000 telephone • 512-804-4811 fax • www.tdi.texas.gov

MEDICAL FEE DISPUTE RESOLUTION FINDINGS AND DECISION

GENERAL INFORMATION

Requestor Name and Address

THE BACK AND NECK INSTITUTE
6211 EDGEMERE SUITE 1
EL PASO TX 79925

Respondent Name

AMERICAN HOME ASSURANCE CO

Carrier's Austin Representative Box

Box Number 19

MFDR Tracking Number

M4-11-1693-01

REQUESTOR'S POSITION SUMMARY

Requestor's Position Summary: "According to the carrier; these Procedures are denied because the benefits for these services are included in the payment/allowance for another procedure. It states on the denial this was reviewed with application of Medicare policies. Per CCI edits and Medicare guidelines CPT codes 22325.59, 63047.59 and 63048 may be billed with modifier 59 and should be paid. According to the denial CPT code 72100.26 was not documented. We feel the attached documentation supports our appeal." "Procedures 22325 were considered to be included with procedures 63047 and 63048. After reviewing the National Correct Coding Initiative edits, we found that the code combination of 22325 with 63047 and 63048 is allowed with a modifier. You also denied benefits for procedure code 72100.26 stating there was no documentation. Please review the enclosed operative notes and also refer to Dr. Urrea's letter." "The procedures performed on [Claimant] were: L5 laminectomy and S1 laminectomy. These are 2 different levels. The CPT code 63047 is used as the primary procedure code for the first level. The AMA CPT has designed the code 63048 for each additional level surgery to the primary procedure code 63047. It also states that 63048 CPT code is exempt from a modifier 51. Modifier 59 was attached to indicate a separate and distinct procedure." "An intra-operative x-ray, CPT 72100.26, was ordered and immediately interpreted by Dr. Urrea. From Dr. Urrea's x-ray reading, operative action was taken. The x-ray is not an integral part of the surgery. It is an additional tool and a seperate procedure for the treatment of the patient." "Dr. Urrea should be paid in full for the professional component of the CPT 72100.26. The reading of the x-ray by a radiologist long after the surgery is finished is insignificant and was not used for the treatment at hand."

Amount in Dispute: $15,435.00

RESPONDENT'S POSITION SUMMARY

Respondent's Position Summary: "**22325-59 correctly denied for reimbursement…this procedure was not requested or approved for pre-authorization…Service also NOT FULLY DOCUMENTED AS A SEPARATE, INDEPENDENDENT PROCEDURE.** Operative report states this 'internal fixation was done with the cage and posterior screws.' THE CAGE & SCREWS/FUSIONS WERE BILLED & PAID SEPARTELY ON THIS BILL, AS 22612, 22630 & 22851. A separate fixation procedure specifically for reduction of a fracture vertebra or dislocation, unrelated to the 2 paid arthrodesis procedures & cage application, is NOT DOCUMENTED." "**63047 & 63048 correctly denied for reimbursement. 63048 additional level of decompression was not requested or approved for preauth & is not fully/separately documented**. Operative report confirms L5 & S1 laminectomies both performed for decompression of L5-S1 spinal canal / L5 nerve roots only. This is considered 1 level of decompression. Per NCCI Edits, 63047 is not separately reportable with 22630, with a modifier status of '1'…**As 22630 & 63047 were performed in same op session, same site, same level & as decompression is a component of 63047 / 48 descriptor, modifier 59 exception is not supported**." "**72100-26 correctly denied for reimbursement.** Reportable for lumbosacral spine formal radiological interpretation & complete report, this is not documented. Billed for intraoperative lumbosacral x-ray interpretation as confirmation of good placement of cage & screws & good reduction of spondylolisthesis, this is not separately reportable."

Response Submitted by: Claims Management, Inc., P.O. Box 1288, Bentonville, AR 72712-1288

SUMMARY OF FINDINGS

Dates of Service	Disputed Services	Amount In Dispute	Amount Due
March 30, 2010	CPT Code 22325-59	$5415.00	$0.00
	CPT Code 63047-59	$7435.00	$771.07
	CPT Code 63048	$2425.00	$309.94
	CPT Code 72100-26	$160.00	$0.00
TOTAL		$15,435.00	$1081.01

FINDINGS AND DECISION

This medical fee dispute is decided pursuant to Texas Labor Code §413.031 and all applicable, adopted rules of the Texas Department of Insurance, Division of Workers' Compensation.

Background

1. 28 Texas Administrative Code §133.307 sets out the procedures for resolving a medical fee dispute.
2. 28 Texas Administrative Code §134.203, titled *Medical Fee Guideline for Professional Services*, set out the fee guideline s for the reimbursement of workers' compensation professional medical services provided on or after March 1, 2008.
3. 28 Texas Administrative Code §134.600, titled *Preauthorization, Concurrent Review, and Voluntary Certification of Health Care*, effective May 2, 2006 requires preauthorization for spinal surgeries**.**
4. 28 Texas Administrative Code §133.308, titled *MDR by Independent Review Organization,* effective May 25, 2008, sets out the procedure for the IRO process.
5. The services in dispute were reduced/denied by the respondent with the following reason codes:

   Explanation of benefits dated May 24, 2010

   - W1-Workers compensation state fee schedule adjustment.
   - 22325-Reportable for open treatment/reduction of vertebral fracture or dislocation, determined as not separately compensable. Op report documents treatment of the spondylisthesis accomplished with the cage & posterior screw internal fixation, billed & paid as 22612, 22630, & 22851 on this bill. An additional, separate procedure is not documented.
   - 63047 & 63048-laminectomy / decompression, not separately reportable with 22630 per NCCI Edits.
   - 72100-26-reportable for interpretation.
   - 285-Please refer to the note above for a detailed explanation of reduction.

- 97-Payment adjusted because the benefit for this service is included in the payment/allowance for another service/procedure that has already been adjudicated.
- 903-In accordance with clinical based coding edits (National Correct Coding Initiative/Outpatient Code Editor), component code of comprehensive surgery; Endocrine, Nervous, Eye and Ocular Adnexa, Auditory Systems Procedure (60000-69999) has been disallowed.

Explanation of benefits dated September 14, 2010

- W1-Workers compensation state fee schedule adjustment.
- 22325-Reportable for open treatment/reduction of vertebral fracture or dislocation, determined as not separately compensable. Op report documents treatment of the spondylisthesis accomplished with the cage & posterior screw internal fixation, billed & paid as 22612, 22630, & 22851 on this bill. An additional, separate procedure is not documented.
- 63047 & 63048-L5 & S1 laminectomy / decompression, not separately reportable with 22630 L5-S1 interbody fusion, per NCCI Edits. As both procedures performed in same Op session, via same incision, & as Op report documents exact descriptors of both procedures, on which Edits are based, modifier 59 exception is not supported. Correctly denied for pmnt.
- 72100-26-reportable for interpretation/formal report of lumbosacral sray,[sic] not documented. (Intraoperative films for placement / guidance, are not separately reportable.) Reconfirmed as integral to primary procedures; x-ray utilized for intraoperative guidance / confirmation; not a separate diagnostic study unrelated to the surgery. Correctly denied for pmnt.
- 285-Please refer to the note above for a detailed explanation of reduction.
- 97-Payment adjusted because the benefit for this service is included in the payment/allowance for another service/procedure that has already been adjudicated.
- 903-In accordance with clinical based coding edits (National Correct Coding Initiative/Outpatient Code Editor), component code of comprehensive surgery; Endocrine, Nervous, Eye and Ocular Adnexa, Auditory Systems Procedure (60000-69999) has been disallowed.
- 1014-The attached billing has been re-evaluated at the request of the provider. Based on this re-evaluation, we find our original review to be correct. Therefore, no additional allowance appears to be warranted.

Explanation of benefits November 14, 2010

- W1-Workers compensation state fee schedule adjustment.
- 197-Payment denied/reduced for absence of precertification/authorization.
- 5056-Preauthorization not obtained.
- Also resubmits previous correspondence stating NCCI Edits indicate 63047 & 63048 may be billed with 22630 with modifier 59. Also states 22325 is documented in Operative note. References L5 & S1 laminectomies performed, stating 2 different levels; that 63048 is for each additional level & is exempt from modifier 51. States 72100-26 should be paid, as the x-ray is not an integral part of the surgery; it is an additional tool & a separate procedure. States the reading of the x-ray by a radiologist after surgery is finished is insignificant.
- 285-Please refer to the note above for a detailed explanation of reduction.
- 97-Payment adjusted because the benefit for this service is included in the payment/allowance for another service/procedure that has already been adjudicated.
- 903-In accordance with clinical based coding edits (National Correct Coding Initiative/Outpatient Code Editor), component code of comprehensive surgery; Endocrine, Nervous, Eye and Ocular Adnexa, Auditory Systems Procedure (60000-69999) has been disallowed.
- 1014-The attached billing has been re-evaluated at the request of the provider. Based on this re-evaluation, we find our original review to be correct. Therefore, no additional allowance appears to be warranted.

Issues

1. Does a compensability issue exist in this dispute?
2. Did the requestor obtain preauthorization for the disputed services billed under CPT code 22325-59?
3. Does the documentation support billing of CPT code 22325-59? Is the requestor entitled to reimbursement?
4. Does the documentation support billing of CPT code 63047-59? Is the requestor entitled to reimbursement?
5. Does the documentation support billing of CPT code 63048? Is the requestor entitled to reimbursement?
6. Does the documentation support billing of CPT code 72100-26? Is the requestor entitled to reimbursement?

Findings

1. The respondent denied reimbursement of CPT code 22325-59 based upon explanation "22325-Reportable for open treatment/reduction of vertebral fracture or dislocation, determined as not separately compensable."

   A Contested Case Hearing Decision and Order signed and dated September 28, 2004 found that "The compensable injury sustained on February 8, 2004 does include lumbar MRI findings dated March 19, 2004 of a shallow central disc protrusion at L5-S1 slightly asymmetric to the right not displacing the traversing nerve roots but does not include lumbar MRI findings dated May 19, 2004 of lower dorsal spine degenerative disc disease and/or an injury to the right sacroiliac joint."

   The requestor billed diagnosis codes "722.10-Lumbar disc displacement"; "724.4-Lumbosacral neuritis NOS"; and "724.2-Lumbago" for CPT code 22325-59. The Division finds that a compensability issue does not exist in this dispute.

2. The respondent denied reimbursement for CPT code 22325-59 based upon reason codes "197-Payment denied/reduced for absence of precertification/authorization"; and "5056-Preauthorization not obtained".

   28 Texas Administrative Code §134.600(p)(3) requires preauthorization for spinal surgery.

   28 Texas Administrative Code §134.600(f)(1) and (2) states "The requestor or employee shall request and obtain preauthorization from the carrier prior to providing or receiving health care listed in subsection (p) of this section. Concurrent review shall be requested prior to the conclusion of the specific number of treatments or period of time preauthorized and approval must be obtained prior to extending the health care listed in subsection (q) of this section. The request for preauthorization or concurrent review shall be sent to the carrier by telephone, facsimile, or electronic transmission and, include the: (1) specific health care listed in subsection (p) or (q) of this section; (2) number of specific health care treatments and the specific period of time requested to complete the treatments."

   28 Texas Administrative Code § 133.308(a)(1) states "Applicability. The applicability of this section is as follows. This section applies to the independent review of network and non-network preauthorization, concurrent, or retrospective medical necessity disputes that is remanded to the Division or filed on or after May 25, 2008."

   28 Texas Administrative Code § 133.308 (p)(1)(E) states "IRO Decision… a statement that clearly states whether or not medical necessity exists for each of the health care services in dispute."

   The Division finds that neither party to this dispute submitted a copy of the preauthorization request/approval/denial report for review. However, a copy of the IRO review report was submitted that found the following services were medically necessary: "IT is determined that the 63047 Posterior Lumbar Decompression L5-S1, 22612 Posterior Lumbar Spine Fusion of L5-S1, 22852 Application of Spine Prosthetic Device, 99221 Inpatient Hospital Stay x 5 Days are medically necessary to treat this patient's condition."

   The Division finds that the IRO report does not list CPT code 22325-59; therefore, the insurance carrier's denial of CPT code 22325-59 based upon "197" and "5056" is supported.

3. The respondent also denied reimbursement for CPT code 22325-59 based upon explanation "22325-Reportable for open treatment/reduction of vertebral fracture or dislocation, determined as not separately compensable. Op report documents treatment of the spondylisthesis accomplished with the cage & posterior screw internal fixation, billed & paid as 22612, 22630, & 22851 on this bill. An additional, separate procedure is not documented."

   28 Texas Administrative Code §134.203(b)(1), states "(b) For coding, billing, reporting, and reimbursement of professional medical services, Texas workers' compensation system participants shall apply the following: (1) Medicare payment policies, including its coding; billing; correct coding initiatives (CCI) edits; modifiers; bonus payments for health professional shortage areas (HPSAs) and physician scarcity areas (PSAs); and other payment policies in effect on the date a service is provided with any additions or exceptions in the rules."

   CPT code 22325-59 is defined as "Open treatment and/or reduction of vertebral fracture(s) and/or dislocation(s), posterior approach, 1 fractured vertebra or dislocated segment; lumbar".

   The requestor submitted a copy of the Operative report and marked the area to support CPT code 22325 which states "Open reduction, internal fixation of the L5-S1 spondylolisthesis was achieved by sequential dilatation of the intervertebral disk space from a 6mm to a 9mm. Internal fixation was done with the cage and posterior screws." Per NCCI Edits, 22325 is a component of CPT code 63047. A modifier may be allowed if appropriate. The requestor used modifier 59 to differentiate 22325 as a separate procedure.

   Modifier 59 is defined as "Under certain circumstances, it may be necessary to indicate that a procedure or service was distinct or independent from other non-E/M services performed on the same day. Modifier 59 is used to identify procedures/services, other than E/M services, that are not normally reported together, but are

appropriate under the circumstances. Documentation must support a different session, different procedure or surgery, different site or organ system, separate incision/excision, separate lesion, or separate injury (or area of injury in extensive injuries) not ordinarily encountered or performed on the same day by the same individual. However, when another already established modifier is appropriate it should be used rather than modifier 59. Only if no more descriptive modifier is available, and the use of modifier 59 best explains the circumstances, should modifier 59 be used." The documentation does not support a different session, different procedure or surgery, different site or organ system, separate incision/excision, separate lesion, or separate injury; therefore, the use of modifier 59 is not supported. Furthermore, the operative report does not support the above description of CPT code 22325-59. Therefore, reimbursement is not recommended.

4. The respondent denied reimbursement for CPT code 63047-59 based upon reason codes "97-Payment adjusted because the benefit for this service is included in the payment/allowance for another service/procedure that has already been adjudicated"; "903-In accordance with clinical based coding edits (National Correct Coding Initiative/Outpatient Code Editor), component code of comprehensive surgery; Endocrine, Nervous, Eye and Ocular Adnexa, Auditory Systems Procedure (60000-69999) has been disallowed" and "63047 & 63048-L5 & S1 laminectomy / decompression, not separately reportable with 22630 L5-S1 interbody fusion, per NCCI Edits. As both procedures performed in same Op session, via same incision, & as Op report documents exact descriptors of both procedures, on which Edits are based, modifier 59 exception is not supported. Correctly denied for pmnt".

   CPT code 63047 is defined as "Laminectomy, facetectomy and foraminotomy (unilateral or bilateral with decompression of spinal cord, cauda equina and/or nerve root[s], [eg, spinal or lateral recess stenosis]), single vertebral segment; lumbar".

   Based upon the IRO report, CPT code 63047 was found to be medically necessary. In addition, per NCCI edits, this code is not bundled to any other procedure billed on the date; therefore, the insurance carrier's denial based upon "97" and "903" is not supported. Reimbursement is recommended per 28 Texas Administrative Code §134.203.

   Review of Box 32 on the CMS-1500 the services were rendered in zip code 79902, which is located in El Paso County.

   The MAR for CPT 63047 in El Paso County is $1542.13. CPT code 63047 is subject to multiple procedure discounting; therefore, $1542.13 X 50% = $771.07. The respondent paid $0.00. The difference between the MAR and amount paid is $771.07; this amount is recommended for reimbursement.

5. The respondent denied reimbursement for CPT code 63048 based upon reason codes "97-Payment adjusted because the benefit for this service is included in the payment/allowance for another service/procedure that has already been adjudicated"; "903-In accordance with clinical based coding edits (National Correct Coding Initiative/Outpatient Code Editor), component code of comprehensive surgery; Endocrine, Nervous, Eye and Ocular Adnexa, Auditory Systems Procedure (60000-69999) has been disallowed" and "63047 & 63048-L5 & S1 laminectomy / decompression, not separately reportable with 22630 L5-S1 interbody fusion, per NCCI Edits. As both procedures performed in same Op session, via same incision, & as Op report documents exact descriptors of both procedures, on which Edits are based, modifier 59 exception is not supported. Correctly denied for pmnt".

   CPT code 63048 is defined as "Laminectomy, facetectomy and foraminotomy (unilateral or bilateral with decompression of spinal cord, cauda equina and/or nerve root[s], [eg, spinal or lateral recess stenosis]), single vertebral segment; each additional segment, cervical, thoracic, or lumbar (List separately in addition to code for primary procedure)."

   Based upon the IRO report, CPT code 63048 was found to be medically necessary. In addition, per NCCI edits, this code is not bundled to any other procedure billed on the date; therefore, the insurance carrier's denial based upon "97" and "903" is not supported. Reimbursement is recommended per 28 Texas Administrative Code §134.203.

   Review of Box 32 on the CMS-1500 the services were rendered in zip code 79902, which is located in El Paso County.

   The MAR for CPT 63048 in El Paso County is $309.94. The respondent paid $0.00. The difference between the MAR and amount paid is $309.94; this amount is recommended for reimbursement.

6. The respondent denied reimbursement for CPT code 72100-26 based upon reason codes "72100-26-reportable for interpretation/formal report of lumbosacral sray,[sic] not documented. (Intraoperative films for placement / guidance, are not separately reportable.) Reconfirmed as integral to primary procedures; x-ray utilized for intraoperative guidance / confirmation; not a separate diagnostic study unrelated to the surgery. Correctly denied for pmnt".

CPT code 72100-26 is defined as “Radiologic examination, spine, lumbosacral; 2 or 3 views”.

Based upon the Operative report the requestor marked the area to support CPT code 72100-26 which states “An AP and lateral lumbosacral x-ray revealed good placement of the cage and screws.” The guidance technique for the procedure is inclusive in the primary procedure performed. The requestor did not submit a report to support this service was separate from primary procedure; therefore, reimbursement is not recommended.

Conclusion

The Division would like to emphasize that individual medical fee dispute outcomes rely upon the evidence presented by the requestor and respondent during dispute resolution, and the thorough review and consideration of that evidence. After thorough review and consideration of all the evidence presented by the parties to this dispute, it is determined that the submitted documentation support additional reimbursement sought by the requestor. The Division concludes that the requestor supported its position that reimbursement is due. As a result, the amount ordered is $1081.01.

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ORDER

Based upon the documentation submitted by the parties and in accordance with the provisions of Texas Labor Code Sections 413.031 and 413.019 (if applicable), the Division has determined that the requestor is entitled to additional reimbursement for the services involved in this dispute. The Division hereby ORDERS the respondent to remit to the requestor the amount of $1081.01 plus applicable accrued interest per 28 Texas Administrative Code §134.130, due within 30 days of receipt of this Order.

Authorized Signature

		5/9/2012
Signature	Medical Fee Dispute Resolution Officer	Date

YOUR RIGHT TO REQUEST AN APPEAL

Either party to this medical fee dispute has a right to request an appeal. A request for hearing must be in writing and it must be received by the DWC Chief Clerk of Proceedings within **twenty** days of your receipt of this decision. A request for hearing should be sent to: Chief Clerk of Proceedings, Texas Department of Insurance, Division of Workers Compensation, P.O. Box 17787, Austin, Texas, 78744. The party seeking review of the MDR decision shall deliver a copy of the request for a hearing to all other parties involved in the dispute at the same time the request is filed with the Division. **Please include a copy of the *Medical Fee Dispute Resolution Findings and Decision*** together with any other required information specified in 28 Texas Administrative Code §148.3(c), including a **certificate of service demonstrating that the request has been sent to the other party**.

Si prefiere hablar con una persona en español acerca de ésta correspondencia, favor de llamar a 512-804-4812.